EMERGENCY INFORMATION

PLEASE KEEP UP TO DATE! Review every 6 months.
Fill in with pencil for ease in making changes.

Date of last review: ____/____/____

PERSONAL INFORMATION

Name:			**Sex: M | F**
Address:			
Doctor:		**Phone #:**	
Preferred Hospital:			

EMERGENCY CONTACTS

Name:		**Phone #:**	
Address:			
Name:		**Phone #:**	
Address:			
Name:		**Phone #:**	
Address:			

MEDICAL DATA

Special Conditions & Notes:

Medication	Dosage	Frequency

Pharmacy:		**Phone #:**	
Date of Birth:			
Blood Type:		**Religion:**	

Health Care Proxy on file at:

Living Will on file at:

Phone Lock Code:

SEE BACK FOR ADDITIONAL INFORMATION

Recent Surgery:	**Date:** ____/____/____

Do you have an EMS-NO CPR Directive or a DNR form? YES | NO
Where is it located?

MEDICAL CONDITIONS | Circle all that exist

None	Clotting Disorder	Hemodialysis
Heart Valve Prosthesis	Coronary Bypass Graft	Diabetes/Insulin Dependent
Adrenal Insufficiency	Dementia	Hepatitis-Type [ ]
Angina	Alzheimer's	Hypoglycemia
Asthma	Hemolytic Anemia	Laryngectomy
Bleeding Disorder	Eye Surgery	Leukemia
Cancer	Glaucoma	Lymphomas
Cardiac Dysrhythmia	Hearing Impaired	Memory Impaired
Vision Impaired	Migraines	Arthritis
Cataracts	Abnormal EKG	Myasthenia Gravis
Pacemaker	Renal Failure	Seizure Disorder
Stroke	Tuberculosis	Sickle Cell Anemia

Other:

ALLERGIES | Circle all that exist

No known allergies	Aspirin	Insect Stings
Penicillin	Barbiturate	Latex
Sulfa	Codeine	Lidocaine
Tetracycline	Demerol	Morphine
X-Ray Dyes	Horse Serum	Novocain

Other:

MEDICAL INSURANCE

Med. Ins. Co:

Policy #:	

Other Med. Ins. Co:

Policy #:	

Medicaid #:

Medicare #:

Additional Notes:

Questions?
Contact Mona McDonald at
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PURSUE LIFE
Adult Ministry